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COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

1974-1976

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LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

BIENNIAL REPORT 1974-1976

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Liston A. Witherill, Director
Department of Health Services

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March 15, 1977

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Honorable Board of Supervisors
383 Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Gentlemen:

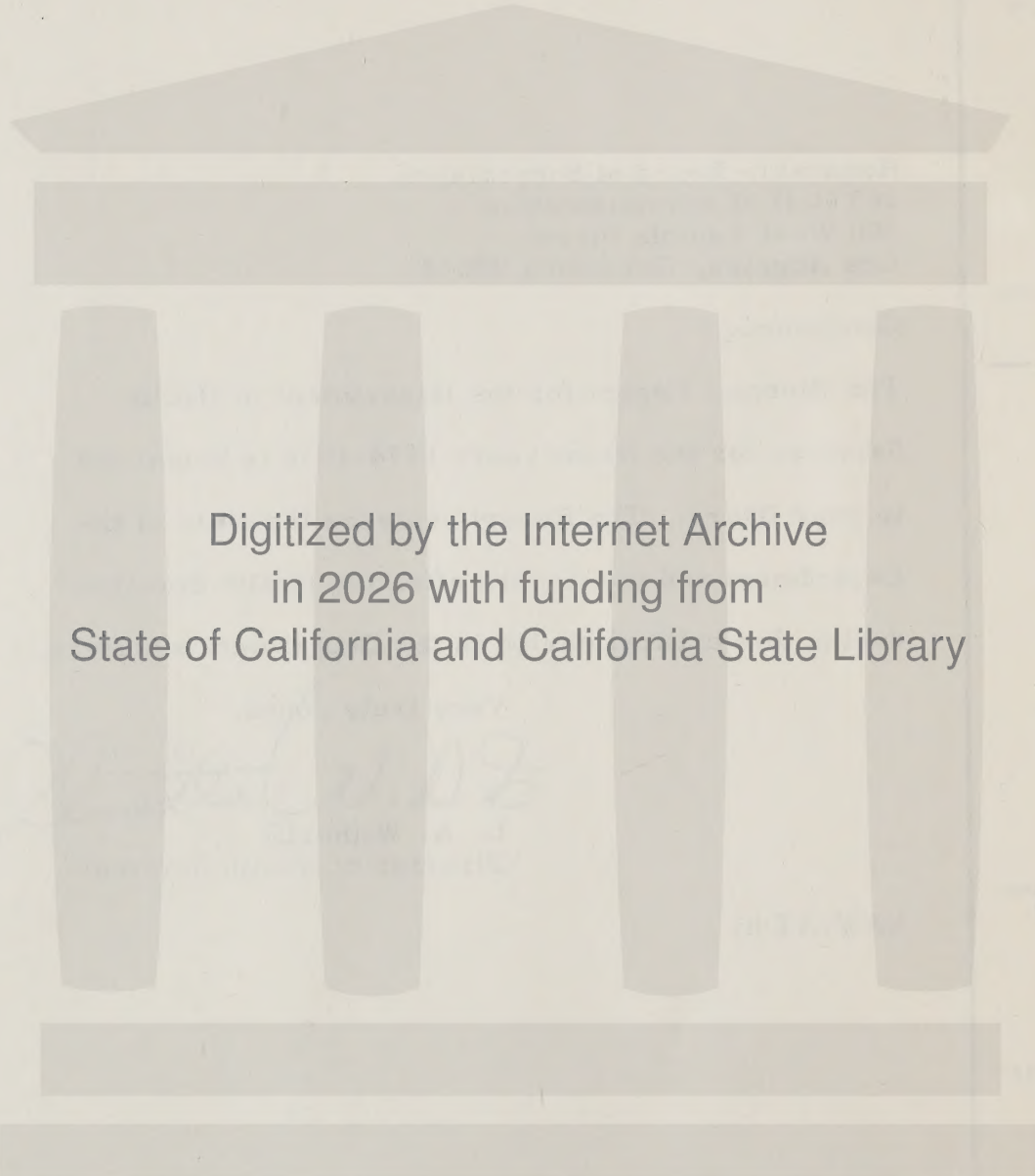
The Biennial Report for the Department of Health Services for the fiscal years 1974-1976 is submitted to your Board. The Report analyzes the state of the Department and the factors affecting Health Services during this critical period in the Department's history.

Very truly yours,

L. A. Witherill
Director of Health Services

LAW:AT:hi

CURING IS COSTLY... PREVENTION PRICELESS!



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LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

BIENNIAL REPORT 1974-1976

LISTON A. WITHERILL, DIRECTOR

INTRODUCTION

The action by the Board of Supervisors in 1972 to unify the departments providing health services assumed an added significance during 1974-76 as a result of the serious fiscal problems affecting the delivery of health care in Los Angeles County. The leveling off and withdrawal of federal and state funding, the inequities created by the Medi-Cal Reform Act, the increased shifting of the cost of health care to the relatively inexpansive local property tax, and the resultant budgetary shortages have placed into sharper clarity the necessity of a unified approach in (1) confronting health issues facing the entire county; (2) making the difficult decisions as to where cut-backs must be made in order to protect the essential preventive public health and acute mental health services and to maintain the existing staffing levels in acute medical-surgical and inpatient rehabilitative services; and (3) asserting the strict controls from a single office over hiring and expenditures and basing these decisions on department-wide priorities rather than from the perspective of individual components within the department.

The fiscal situation is the gravest the department has experienced in recent history and the outlook for the future is similarly critical unless the state legislature takes action which would reduce the county's Medi-Cal obligation which today is at $138 million. This situation further stresses the importance of the department's effort since the 1972 merger to study the entire range of health services and to eliminate duplicated and fragmented services which had characterized the previously unstructured health system lacking in any significant interrelationships between the various departments.

Perhaps at no other time has the department been put to the test with the degree of intensity as it has during the past two years. The challenges are to be expected. Health care is an extremely volatile subject throughout the nation and has become the focal point for the expression of many of the strongest anxieties felt in our society. As the gap between the expectation and the availability of health services widens, both the consumer and the health professional can be expected to step up their public actions.

Locally these actions have included:

-- Strikes by interns and residents in the county hospitals.

-- Public protests of service reductions at hearings before the Board of Supervisors.

-- Withdrawal of services by private doctors protesting spiraling malpractice insurance rates.

-- A demand by consumer groups for a greater voice in determining local health priorities.

These actions have not been confined to Los Angeles County. In contrast to the chaotic situations in both New York and Chicago, this county has been able to control potential massive disorders in the health care system. Strikes by interns and residents here during the last two years have been settled without serious disruption of services and, equally important, without the bitter aftereffects characterizing the New York and Chicago strikes. The withdrawal of services by private physicians in January 1976 over high malpractice insurance premiums created a potentially disasterous situation which could have easily deteriorated had it not been for the coordinative actions by the Department of Health Services. This meant asserting a control over referrals throughout the county to assure that patients were taken to hospitals capable of taking care of them and carrying out actions enabling county hospitals to respond to the most serious medical needs.

The aftereffects of the private physicians' strike still exist. Many private doctors are no longer giving care to Medi-Cal patients who might constitute an insurance risk, e.g., obstetrical cases. The result has been a shift of patients from the private to the public

sector. For example, one study showed that forty-three per cent of obstetrical patients in county hospitals had prior deliveries at private hospitals but are now finding they can no longer obtain private care. This is particularly true in the San Gabriel Valley where the department developed contracts for obstetrical care at Pomona Valley Community Hospital and Whittier Presbyterian Intercommunity Hospital. Unfortunately, the Whittier hospital was forced to cancel its contract as a direct result of the malpractice crisis.

A second consequence has been that our acute hospitals are running either at or above budgeted patient levels. For example, Martin Luther King, Jr. General Hospital at one point was operating at 10.7 per cent above the budgeted levels while Los Angeles County-USC Medical Center had a thirteen per cent increase in new patients in June 1976 compared to June 1975.

These demands for increased services have come at a time when our resources have been seriously diminished as a result of several factors, including those previously stated dealing with the leveling off and withdrawal of state and federal support; spiraling health costs and the property tax ceiling imposed by the state; and budgetary reductions amounting to $7 million and 450 positions. The departmental action to control expenditures necessitated a strict hiring freeze which in turn brought staffing levels to a critical low point and consequently jeopardized accreditation requirements which have become more stringent and complex each year.

The freeze was delayed until March 2, 1976, to allow the hospitals' patient count to stabilize following the end of the malpractice action. Under the freeze only vacant positions critical to patient care could be filled. In July 1976 review teams were sent by the Director of Health Services into the acute hospitals to determine measures to deal with problems arising from reductions and the freeze. The impact was severe. Hospitals were forced to close intensive care units, consolidate wards, cope with extensive overcrowding, transfer obstetrical patients from LAC/USC Medical Center to King and Harbor hospitals, and initiate early discharges. As a result of this review, authorization was given to hire up to ninety per cent of budgeted positions in nursing (wards and intensive care), laboratory and radiology, and 95 per cent of budgeted nursing positons at LAC/USC Medical Center.

The public must realize that many of these conditions, translated into human terms, mean increased suffering for persons who cannot afford or in many cases obtain private care. Any intensification of an across the board freeze would only further jeopardize the quality levels which are now precarious. Without substantial relief from Sacramento, the Department of Health Services will have to make serious program curtailments rather than to allow the essential protective public health, mental health and acute medical-surgical and rehabilitative services to reach substandard levels.

MAJOR HEALTH ISSUES

Medi-Cal Share

Although the Medi-Cal Reform Act of 1971 was intended to expand coverage to indigents not previously covered, the act has failed to achieve its intention. The result is that Los Angeles County is paying twice: first, in the county contribution to Medi-Cal, now amounting to $138 million, and, second, when care is provided at county expense to persons unable to become eligible. Legislation has been recommended that would tie the county share to a percentage increase in population rather than to assessed valuation. It is estimated this would save $12 million annually.

Inpatient Reimbursement

The ten per cent ceiling by the state on increases in Medi-Cal inpatient reimbursement has been struck down by the courts. Legislation has been called for which will enable public hospitals to be reimbursed at actual cost or at not lower than Medicare limits. The dollar loss over the last two years is estimated at $22 million.

Outpatient Reimbursement

Here again is an example of the state shifting the financial burden to the counties. Based on the schedule of maximum reimbursement, the county receives about fifty cents on a dollar for every Medi-Cal patient. An $8 million loss is predicted for 1976-77.

Simplified Eligibility

In the area of outpatient services, the cost of determining eligibility is higher than the potential reimbursement. Eligibility requirements need to be waived to create a simplified system. Result would be that funds now being spent on administrative costs could be redirected toward patient care.

Pre-Paid Health Plans

The State Department of Health lacks the authority to enforce payment by the Pre-Paid Health Plans to the county which has provided emergency care to plan members. This could be alleviated through state arbitration and authority for enforcement.

California Health Services Act

The California Health Services Act is a first step towards a rational, accessible, economical, and comprehensive system of health care for the poor in California. It provides a basis for restoration of the traditional partnership between the State and County to provide health care for the poor.

It provides for a two-year immediate fiscal relief to counties for health services in addition to a long-term solution in the financing of county hospitals. The bill creates a task force composed of both County and State officials to develop a cost sharing between the counties and the State to be implemented in 1979-80.

In addition it provides a streamlining of administrative systems which will save administrative cost both for the counties and the State.

Care to Undocumented Aliens

The growing financial burden upon the county taxpayer for care given to undocumented aliens could be relieved through legislation requiring federal or state reimbursement to the county for the cost of providing emergency and public health care services. Despite the fact that entry of nonresident aliens is a national responsibility, the federal government does not share in the cost of providing this care.

Sub-Acute Care

Patients requiring long-term service above the skilled nursing home level are routinely refused care in nursing homes because of the low reimbursement rate. The county must care for these patients but then is compensated for only minimal services. A sub-acute rate must be established to erase this inequity.

HEALTH SERVICES:

THE EVOLUTION OF A DEPARTMENT

One of the principal difficulties in understanding the effectiveness of the Department of Health Services lies in the tendency to judge the entire department's performance by looking at a single program. This inevitably occurs when public attention is fixed on a single subject involving only one aspect of the department as is often the case because health services, by its very nature, involves people's

lives, cuts across segments of society, and becomes the focus of public debate and media attention. An excellent example of this is the swine flu control program which began at the close of the fiscal year and which dominated public attention amidst a swirl of national and local controversy. For all of its activity, the influenza control program remained but one part of the massive Health Services program which day in and day out must confront the difficult task of trying to protect the health of the community and to care for the huge numbers of persons asking for care in our hospitals. The result is a complexity of needs and services which are closely related and which together form the unity which is the Department of Health Services.

Despite the controversies which have occurred in the past and may inevitably occur in the future, the people of Los Angeles are now receiving more for their health dollar in the public sector than they have ever received before or could have been possible under a system which lacked any principle of unity. This has been achieved through:

-- The continuous effort by the DHS to bring the administration and delivery of health services closer to the communities served in order that these services can more closely reflect the needs and priorities of these communities.

-- The effort in the regional programs to unify preventive and curative services and thereby strengthen the quality of health care given in the health centers and hospitals.

-- The hard look taken at all programs to find ways of consolidating and, if necessary, eliminating duplicated services at a time when the serious fiscal situation demands that all excess be cut out of the health system.

This is not to say that the process since the merger has been a smooth one nor should it be. It was the first time in the nation that a merger of health services had been attempted on such a grand scale, and the rapid changes very quickly rocked a system unaccustomed to change. The Public Commission on County Government noted that national health experts praised Los Angeles County for this type of innovative action. The development of the first pilot regional programs in the Coastal and San Gabriel Regions during the first year and the continuing changes were of necessity wrenching and disturbing. The task was to create a new department, not simply to add another layer of bureaucracy, and the process of consolidation and change reaching into every program was exactly what was needed to begin the evolution into a strong and effective department capable of dealing with the critical health issues becoming more demanding each year. The lessons learned have been important. Looking back, the unification process would have been speeded if all regions had gone into operation at the same time, which would have eliminated a state in which part of the department was operating under a unified principle while the

remainder continued according to the former separate system.

Neither the County of Los Angeles nor the private sector will be able to afford a fragmented nonsystem of health care. The development of the DHS is the first substantial step toward a coordinative approach for all health services. Given the fiscal realities described in this report, the movement in the DHS toward a network system must necessarily proceed much more slowly than was foreseen in 1972, and every step must be adequately financed.

The goal remains to create a health network linking hospitals and health centers providing comprehensive care, as envisioned in the Bauer Report which contains the philosophy underlying departmental planning. This concept holds that health care can be delivered most efficiently by unifying all of the previously disparate elements, by creating one door through which a patient gains access to all needed services. This shifts the burden from the patient to the department in selecting where and how the patient should be treated. Further, it demands an end to fragmentation, insists upon an orderly process, and creates the possibility of sound fiscal management.

Despite the severe fiscal constraints, the five Health Services regions (Southeast, San Gabriel, San Fernando-Antelope Valley, Central and Coastal) are areas which can be effectively administered. The regions are succeeding in unifying health programs and in working closely with local communities to assure a responsiveness to priorities and needs unique to the different areas of the county. While no two regions can be alike because of the community differences, the DHS feels that an administrative unity will evolve which will tie the regions together. In these beginning years it is important for each region to discover its own character and individualism because it is through this process that a motivating spirit of regional identification can occur. On a department-wide level, the regional program has enabled the DHS to create administrative units of manageable size, administering programs reasonable in scope. This would not have been possible if all administrative control were centralized in one building remote from the people requiring care.

The Health Services Regions are currently organized along the classic scheme of line and staff function. Regional deputies operate as the senior health executive within their respective region. In that role, the regional deputy is responsible for the day-to-day delivery of health services within resources allocated to the Department by the Board of Supervisors. To assist in the execution of their responsibilities, each regional deputy has a small specialized staff.

Generally speaking, the regional deputy exercises direct line control over all resources within a region. For example, hospital administrator and district health and mental health officers report directly to the regional deputy. Assisting each regional deputy, below the regional staff level, is a small group of nonmedical and medical administrators.

For example, in each region there is at least one hospital with a staff of physician and paramedical specialists. These individuals provide administrative assistance and frequently provide patient services/consultation in the ambulatory care centers. As such the staffs of these centers, that are under the direction of a district health or mental health physician, are augmented by hospital based administrative/medical personnel. This practice strengthens the management of the ambulatory care programs. Also, visits to ambulatory care centers by hospital based physicians offers "on site" specialty medical care/consultation to patients in a general practice setting. Another benefit of this operational model is that preventive public health programs are strengthened in at least two ways: Medical specialty care is available in a less costly ambulatory setting and district health officers and their staffs can concentrate on public health problems.

The above described pattern of health care delivery is the general philosophy followed in organizing the health delivery system in Los Angeles County. The pattern was established following many discussions with leading health care executives from the private sector, federal systems and other public delivery systems.

There exists now a close identification by the regional staffs with their communities, and this in turn has engendered strong working relationships with advisory councils and a perception of the health issues which differ in each region according to its particular sociological, cultural, economic and ethnic character. Encouraging the participation of the local communities in their health care has been a principle DHS objective and the result has been mutually beneficial. We have gone past the time when health planning can be done in isolation. By listening to the advisory councils, encouraging them to speak out on health issues and to advise the regions on important matters, the DHS has gained significant community support and has avoided many of the conflicts seen in other cities arising from a basic lack of communication and a distrust between consumer and provider.

PROGRAMS

Office of the Medical Director

The prime goal of the Office of the Medical Director during the biennium was to coordinate the work of the central staffs of the departmental medical programs to extend more effective staff assistance to the regions, in which operations are concentrated. These activities included:

-- Improved coordination of the work of the three programs interrelated through the Short-Doyle mechanism (Mental Health, Drug

Abuse and Alcoholism) was achieved, especially in the area of planning, which is mandated by State law.

-- An Office of Quality Assurance was established to coordinate and monitor the implementation of the laws concerning Professional Services Review Organization (PSRO) and Utilization Review. This office also, in close cooperation with the County's Office of Risk Management and the County's malpractice insurance carriers, coordinates and supervises the Department's activities in malpractice coverage and especially prevention. An important study of the nursing home industry, ordered by the Board of Supervisors, and a pilot project to improve the medical care of nursing home patients, utilizing nurse practitioners, were subsidiary but important activities of this office.

-- By order of the Board of Supervisors the transfer of all medical and psychiatric services presently under the Probation Department was negotiated to bring them under the jurisdiction of this Department.

-- The Comparative Medicine and Veterinarian Services Division was singled out for praise by the World Health Organization and the Food and Agriculture Organization of the United States, and by the 1975-76 Grand Jury.

-- Evaluation of program effectiveness in the fields of drug abuse and alcoholism, where large sums of public monies are placed under contract with private providers, has been increasing in scope and sophistication.

-- An Office of Health Related Professions was established to develop standards, guidelines for training and a master plan for the development and utilization of nurse practitioners and allied health professionals.

Alcohol Treatment and Prevention Programs

Approximately ten per cent of the seven million residents of this County--a total of between six and seven hundred thousand people--are estimated to have a serious alcoholism problem. A Los Angeles County study showed that the estimated overall cost of alcoholism and alcohol abuse to the Los Angeles County government alone in 1972-73 was $139 million. The County District Attorney found that misuse of alcohol was involved in approximately half of all crimes; in addition, fire protection officials estimated that alcoholism was a contributing factor in many fires. Welfare costs were estimated to be nearly $54 million dollars for alcoholism and millions of additional dollars were spent on court costs, law enforcement, and other services. To combat the serious problem of alcohol abuse in this County, the DHS Office of Alcohol Abuse and Alcoholism (OAAA) was established in September of 1972 and became operational in 1973.

In the past two years, Los Angeles County's overall planning, program implementation, administration and evaluation efforts related to alcohol treatment under the direction of the County Alcoholism Administrator has resulted in an effective alcoholism program of treatment, rehabilitation and prevention services for the entire county. These efforts have provided for the orderly development and provision of needed alcoholism services, and has been the basis for the effective utilization of federal, state, and local resources for delivery of alcoholism services. In addition, the planning process for alcoholism services has allowed the local communities the maximum latitude in setting realistic goals and priorities within their needs and capabilities.

Most recently, the California Legislature passed SB 744 during the 1975 legislative session which removed State-funded alcoholism programs from the Short/Doyle community mental health system entirely and placed primary responsibility for program service delivery at the County level. This event culminated many years of alcoholism program development and growth into a comprehensive service delivery system. The County Office on Alcohol Abuse and Alcoholism has recently been phasing-in activities that are to be implemented under SB 744.

Programs

Current alcoholism treatment and prevention programs funded through the Department of Health Services (federal, state and county funds) consist of:

-- Prevention and education services.

-- Identification services--includes information/referral, alcohol traffic safety, occupational alcoholism programs, and supplemental security income.

-- Residential treatment and rehabilitation services--includes outpatient, self-help groups, day treatment, vocational rehabilitation, and drop-in services.

Drug Abuse

Los Angeles County and the West Coast remain major problem areas in the nation in terms of abusers and addicts because of the accessibility of heroin and marijuana. Los Angeles continues to have a severe problem battling drug abuse. The heroin problem has continued to rise over the past two years as evidenced by increased overdose deaths. For every ten opiate related deaths in California, six involve Los Angeles County residents. The increased use of drugs by adolescents is characterized by poly-drug abuse, e.g., alcohol, marijuana and pills (tranquilizers and barbiturates).

Drug abuse funding from federal, state and county sources amounts to $23 million annually. The thrust of the Office of Drug Abuse today has expanded to three previously neglected areas:

-- Developing a county-wide prevention program.

-- Training and technical assistance to community-based programs providing treatment services.

-- Evaluate the outcome of treatment efforts for use in improved planning.

Priorities for new treatment services are:

-- Outpatient detoxification programs to replace decreasing inpatient resources.

-- Special programs for female addicts and their dependents.

-- Specialized residential programs for youths.

-- Expansion of vocational rehabilitation services.

Preventive Health Services

The biennium 1974-76 has seen the establishment of Preventive Health Services on a more definite basis within the overall Department of Health Services. The evolving role of Preventive Health Services has become clearer in the developing relationships with regions. It has taken time and understanding to change organizational relationships which existed prior to the formation of the Department of Health Services in 1972. The role of Preventive Health Services has evolved into one with responsibilities for monitoring, surveillance, consultation, standard setting, quality control and evaluation. The regional role is one of operations. In order for Preventive Health Services to carry out its role effectively, it has been necessary for each program in Preventive Health Services to develop the necessary tools and mechanisms for the collection of data and information. Some of this has existed before but other data and the reporting system had to be developed. Some of this is yet to be accomplished. However, the definition and clarification of roles has led to a greater understanding of the contributions of central and district staff to reach mutually agreed upon goals. The need for continuing and improved communication between Preventive Health Services and Regions is ever present and requires surveillance in and of itself.

A few of the program highlights are as follows:

Tuberculosis has shown an increase in number of cases from 1,308 in 1968 to 1,592 in 1975. This is only partially accounted for by a change in reporting practice. Most likely this is a reflection of

imported disease and the arrival of immigrant populations. Actually the rate for tuberculosis in the white and black populations has decreased; increase is noted in Spanish-surname and oriental peoples. Additional screening and follow-up programs have been started in Central and Southeast Regions. Also preparations have been made to inaugurate a new record and evaluation system for more effective monitoring of the total program, as well as the conducting of regional tuberculosis control program reviews. Tuberculosis remains a major public health problem in Los Angeles County with emphasis on continued vigilance for casefinding and chemotherapy, and chemoprophylaxis, as indicated.

The Venereal Diseases showed a marked escalation for both gonorrhea and infectious syphilis. There have been continued and some expanded efforts at informational, educational, and motivational programs aimed at the private physician, as well as the regional health services staff. The gonorrhea screening program has proven successful; 43.6 per cent of female morbidity was the direct result of this project. A behavior research - evaluation - action study was conducted by the University of Chicago Community and Family Study Center. One important development as result of the study has been a series of video-cassette tapes on various aspects of the sexually transmitted diseases produced in cooperation with University of Southern California. Continuing efforts are being made at assessing the venereal disease program as it functions in regions. More recently the federal funds supporting a portion of the venereal disease program have been cut. This will present an increasing challenge in order to find support funds as replacement.

Immunizations have been maintained through the efforts of the Immunization Project in cooperation with regions and schools. The levels, in general, for the immunizable diseases (diphtheria, pertussis, tetanus, measles, rubella, polio) have remained at satisfactory levels. However this requires constant vigilance and effort to maintain these levels. In more recent months the thrust for immunization has been for the development and implementation of the "swine flu" vaccination program, a major program accomplished in a short time. Over one million flu immunizations were given in this county. Another thrust has been a sharper surveillance and control program for measles. This has resulted in the identification of recent outbreaks of measles with containment by vaccination programs. A threat coming on the horizon is the possibility of vaccine shortages because of certain cutbacks on the part of manufacturers and some questions in regard to patient consents and responsibilities.

The Child Health and Disability Prevention Program is a health screening program directed at all children preceding entry into first grade and all Medi-Cal children from birth to age 21. The foundations of the program have been laid with the establishment of a central administrative staff, regional coordinators and screening staff, and identification and involvement of providers according to State regulations. More recently there have been additional organizational

changes on the State level which may mean a closer working together of EPSDT and Medi-Cal as time goes on. Preliminary figures indicate that about 50 per cent of the children screened, mostly five-year-olds, had some condition found requiring referral for follow-up.

Family Planning exists as a categorical clinic in twenty health districts at thirty-eight locations. It is also integrated into youth and ambulatory health clinics. The program relates to the Los Angeles Regional Family Planning Council, Inc., for a portion of its funding for services with a projected level of $1.4 million from this source. This service is comprehensive and includes education, counseling and provision of all types of contraceptive methods. Clinic sessions have remained about 2,300 - 2,400, with an anticipated jump to 6,400 with program expansion.

Future

The future of Preventive Health Services lies in the continued recognition of the importance of prevention as an integral part of the total health services. Those preventive services which have been proven must receive priority and must remain the foundation upon which expansion takes place. It does appear that prevention will involve to a much larger extent behavioral changes on the part of individuals. This is particularly true in thinking of prevention of chronic diseases, as well as the more traditional preventive activities in regard to communicable diseases. If this is accepted, then those research findings which sharpen our ability to produce behavior change to improve health will need to be applied to preventive programs.

As the dollars available for health services are more closely examined, it seems reasonable and logical that there will be increasing accent on prevention in order to make these dollars stretch further. It is possible that one can anticipate a preventive program for each person at each age group--from pregnancy through infancy, youth, middle age, old age. And one can anticipate that there will be increasing intolerance for the occurrence of preventable illness in the community.

Environmental Management

Environmental management sanitarians have carried on a concerted investigative effort to strengthen and improve the environment. This is done through a continued educational and enforcement policy. Enforcement includes field notices of violations, educational consultations to correct public health infractions, and administrative office hearings. If compliance is not achieved, public health matters are brought to the attention of the District Attorney and City Attorney for criminal prosecution. The personnel in this division are involved in a wide area of responsibility and have maintained a consistent high standard, which has been a credit to the Department of Health Services.

In fiscal years 1974-75 and 1975-76, District Services personnel conducted over 700,000 field investigations and inspections. This number includes over 160,000 citizen complaints.

Mental Health Services

Program Analysis

Ongoing and complex efforts have been made to reduce length of stay of conservatees in State Hospitals through close monitoring, interagency meeting and amelioration of some systems problems.

In coping with Michael E. Decision that prevented the placement of wards of the court in psychiatric hospitals, procedures for conservatorship for minors were established and implemented. The division was instrumental in bringing about remedial emergency legislation through Mr. Lanterman (AB 3361) that included minors in the 4011.6 P.C. Section and provided for their voluntary admission with counsel's advice.

Mental Health Services has established a Follow-up Team that has been in operation for over a year. This team was created to carry out services mandated by SB 2316 to examine the continuing care system for patients discharged from state, county, and contract Short-Doyle inpatient psychiatric facilities. The continuing care system is being examined in relation to adequacy of Continuing Care Plans, gaps in service, the referral process, outreach attempts, linkage, and services received.

A first quarter report has been submitted which speaks to general trends and the basic charge of the team. The study is being conducted in cooperation with the Evaluation and Research Division of the Program Development Bureau.

Use of State Hospitals continues to decline and local hospital use has lowered.

The transfer of all medical-psychiatric services from Probation Department to Health Services Department was negotiated and is being implemented.

The Mental Health Services has significantly expanded the type of data available for program evaluation and improvement. The evaluation program now includes site visits, client satisfaction surveys and data on client functioning.

Financial Component - 1974-76

In January 1974, Mental Health Services was notified by the State of its preliminary 1974-75 Short-Doyle allocation. The State

had for the first time separately budgeted Mental Illness, Drug and Alcohol programs in the allocation. This made difficult any comparisons with 1973-74 programs and budgets due to the increases in Substance Abuse funding (SB 204, SB 713) obscuring the decrease in Mental Illness funds.

The CAO and the Department of Health Services reached an understanding with the State on which programs the State expected Los Angeles County to fund from which allocation; it then became apparent that the Mental Illness programs were facing a $5.2 million deficit for the 1974-75 fiscal period. In view of this, a hard freeze was imposed on all Mental Health positions becoming vacant in an attempt to reduce 1973-74 expenditures and thus lessen the impact of the reduced level of funding.

In October and November 1974, Mental Health prepared and analyzed the 1973-74 Short-Doyle cost report to determine actual costs of all of our implemented programs. The deficit increased from $5.2 million, based on budget, to $8.07 million due to program inflationary cost increases demonstrated in the cost report. Budgets were then prepared and distributed to the five County Health Services regions reflecting the reduced allocations and the regions were asked to report the deficits the lowered funds would dictate.

Since programs had been ordered to maintain a hard freeze on all positions becoming vacant, the units reported decreases of $2.56 million in estimated mental health total cost for 1974-75, and with an all-out effort, estimated additional Medi-Cal and other revenues in the amount of $2.69 million. These adjustments left $2.82 million of program cost, in excess of the mandated 10 per cent match, which had to be absorbed by the County.

On February 19, 1975 Los Angeles County's allocation was received from the State for the 1975-76 fiscal period. All counties reportedly received a 7 per cent increase on their Mental Illness programs and 10 per cent on Drug and Alcohol programs. The Social Rehabilitation Services (SRS) programs were completely defunded reducing the actual increase in the allocation to only 4.47 per cent. In light of a spiraling inflation rate of 12.38 per cent, coupled with the excess County participation in 1974-75, the County was again faced with potential program curtailments in the amount of $8.3 million.

Public hearings, as provided for mandated by Section 1442.5 of the California Health and Safety Code, were held on the proposed reductions before the Board of Supervisors on June 12, 1975. The Board, faced with cuts in a mental health program already weakened by a year-long freeze and the very real prospects of layoffs of 150 county employees, reduction of 22,000 inpatient days, 135,000 outpatient visits, and 26,000 days of partial hospitalization, voted an additional $7 million of county dollars above the mandated 10 per cent match. The final State allocation reduced this $7 million to $4.2 million. The additional county participation in the Short-Doyle program

enabled Mental Health programs and services to be maintained through fiscal year 1975-76 at the 1973-74 level.

Problem Areas

The level of funding has not been increased at the same rate as to the increase in cost of living.

Preventive mental health services have decreased from the levels of 1970-71 and are still declining within the current fiscal year.

Outpatient services have decreased since fiscal year 1974.

The estimated capacity of the Short-Doyle system is presently less than 50 per cent of estimated need for service.

Relative utilization of services compared with estimated need has not improved during this time period. Coastal has joined San Gabriel Valley and Southeast Health Services Regions as relatively underserved.

Because of funding problems, it has not been possible to provide residential alternatives to hospitalization. Such alternatives could run a wide gamut but do require some special funding.

Comparative Medical and Veterinary Services

It is the duty of Comparative Medical and Veterinary Services to locate, diagnose, prevent, control and eradicate the contagious and infectious diseases of animals, including those transmissible to man; to enforce federal, state and county laws and regulations pertaining to movement and sanitary surroundings of animals; and to provide veterinary services to the Los Angeles County Department of Animal Control including emergency veterinary care for sick and injured animals and operation of spay and neuter clinics.

There are almost as many animals and pet birds as there are people in Los Angeles County -- 6,330,000.

These animals suffer from the same diseases as humans. For every disease in people there is an identical affliction or a closely similar one in some animal species. Over 300 such diseases have been documented. More than 100 diseases are transmitted between animal and man. These must be diagnosed and controlled in animals to prevent spread to other animals and to man. Merger of County Veterinary Services into the Department of Health Services has

materially strengthened the County's ability to diagnose and control diseases of animals, especially those transmissible to man.

In 1974-76, with 22.7 budgeted positions, two of which are part-time student workers, Comparative Medical and Veterinary Services:

-- Operated an approved full-service infectious disease diagnostic laboratory. There were 76,158 laboratory tests and 2,267 post-mortem examinations conducted; 9,572 animal diseases were diagnosed.

-- Conducted 581 indepth investigations of reported man-animal diseases (zoonoses) and instituted control procedures.

-- Conducted 933 investigations of citizen complaints regarding unhealthy or diseased animals, poor sanitation or illegal movement of animals in pet shops, kennels, stables and other animal holding areas.

-- Supervised the proper disposal in rendering works of 60,356,518 pounds of dead animals. The majority of these originated from other counties in California which do not have rendering works.

-- Quarantined 11,368 animals and observed them for rabies; 19,296 animals were vaccinated against rabies and 17,672 vaccinated against other infectious diseases; 37,821 animals were given health examinations; 23,110 animals were given emergency veterinary treatment in animal shelters and other areas.

-- Operated two spay and neuter clinics in cooperation with the Los Angeles County Department of Animal Control. There were 4,373 spay and neuter operations performed.

-- Conducted 80 unannounced inspections of research institutions receiving animals from County-operated animal shelters. These inspections were conducted with representatives of humane organizations.

-- Selected by the World Health Organization and the Food and Agriculture Organization of the United Nations as "an example of a well-developed joint veterinary public health and comparative medical program at the local level of government."

Grand Jury Report

The final report of the 1975-76 Grand Jury stated in part: "In our inspections (of Comparative Medical and Veterinary Services) we found well-equipped laboratories, operating efficiently, staffed by employees who took great pride in their work."

Hospitals

The critical nature of the fiscal problems dominates any discussion of health care. The impact upon our hospitals has been severe, driving staffing levels to serious low points, forcing the consolidation of many services and delaying construction of necessary projects. The work performed at the hospitals under difficult conditions is a tribute to the medical, nursing and administrative expertise within these facilities. The staff has had to cope with an increasing patient load, particularly in areas such as obstetrics where patients are being turned away by the private sector, while at the same time working with reduced staffing levels as a result of both the freeze imposed to avoid cost overruns and the difficulty in recruiting registered nurses, particularly critical care personnel. This freeze was later lifted in accordance with the department's principle to maintain essential care in acute medical and surgical services.

-- The first of the consolidation measures took place at the end of 1973 when El Cerrito Hospital was converted into an ambulatory center.

-- John Wesley Hospital has transferred its inpatient programs, the liver service to Rancho Los Amigos Hospital and the oncology program to LAC/USC Medical Center.

-- The bed configuration at Long Beach General Hospital has been changed. Previously a 300-bed facility with 100 alcohol treatment beds, 50 ortho-stroke beds, and 150 medical-surgical beds, it now has 75 alcohol treatment beds, 50 skilled nursing beds and 85 acute medical-surgical beds.

In the past two years the minimum staffing levels have created tensions among the hospital staffs and have led to demands by the postgraduate physicians as well as the permanent medical staff for increased financial support and for public awareness and action concerning these difficult conditions. In some cases the budgetary cutbacks have threatened the accreditation of certain teaching programs. The reasons are complicated and involve the heavy patient load which impacts on both the residents and supervising physicians, a lack of sufficient allied health personnel and equipment. Withdrawal of accreditation of any teaching program would in effect close the program because it would mean that a department would no longer qualify to teach postgraduate physicians, a situation which would dry up the source of supply of health manpower. These are critical issues which are a direct result of the decreased state and federal support which was detailed at the start of this report, and which threaten to get worse if the level of support does not improve.

Despite the negative impact of the fiscal situation, the DHS hospitals have a national reputation for excellence in treatment,

research and training. Each year thousands of health care professionals trained in county hospitals go out to staff virtually every health facility in Los Angeles County. There are no comparable training institutions on the West Coast.

Some measure of the national regard for our hospitals may be perceived from the following:

-- In 1975 the Robert Wood Johnson Foundation gave eight grants in a national program to reduce risks for mothers and newborn infants. Three of the eight grants totaling $6.6 million went to Martin Luther King, Jr. General Hospital and LAC/USC Medical Center. These awards were given in recognition that these hospitals have the outstanding obstetrical programs in the Los Angeles community and the expertise to advise physicians in the private sector as to the latest techniques in assuring a safe delivery for high risk pregnancies.

Nursing Home Surveillance

The subject of abuse and neglect of nursing home patients was brought to public attention through a series of public hearings early in 1975 by the Board of Supervisors. These hearings made it clear the enforcement of regulations and surveillance by the Health Facilities Division had failed. This resulted in drastic administrative changes and a new policy of aggressive nursing home surveillance to protect the health and rights of patients.

Actions include:

-- A County-wide survey into patients being held against their will;

-- A financial and medical audit of selected nursing homes;

-- Establishment of a computerized nursing home information and referral system;

-- A pilot project studying the feasibility of county physicians providing medical care to certain public guardian wards housed in nursing homes;

-- Creation of a task force to review the quality of care in all nursing homes treating mentally ill patients;

-- A request by the Board of Supervisors to the Board of Medical Quality Assurance for an investigation into the quality of medical care given to patients in nursing homes.

The Health Facilities Division has redirected the priority of the professional consultant staff to developing further in-service

training for all surveyors. It is attempting a new concept of upgrading care through a special team doing structural and timely reviews of facilities with repeated deficiencies. The result of the administrative changes and the new policy has been a significant improvement in the level of nursing home inspections and a degree of protection for the 40,000 persons in 800 nursing homes never before achieved. The Health Facilities has worked closely with the District Attorney and the City Attorney to have legal actions initiated against violators. This has led to an intensification of prosecutions and convictions for nursing home offenses. In summary, a foundation has been established for an effective nursing home surveillance program which can be a model for other states. However, the problem of adequate patient care is deeply imbedded in and complicated by the present nursing home system and will require even greater concentration of effort and commitment by all concerned agencies if we are to make any significant changes. We have made a beginning to assure conformity with regulations but unfortunately conformity alone does not translate into a standard of care with which we should be satisfied.

REGIONAL PROGRAMS

Southeast Region

-- The county's first Comprehensive Care Center opened April 26, 1976. Closely linked with Martin Luther King, Jr. General Hospital, the Southeast Comprehensive Health Center is staffed by eight primary health care teams offering diagnostic, medical, dental, mental health and preventive health services.

-- Specialty clinics have been established with the assistance of professional staff from MLK and the Health Centers. Clinics are senior citizen, neonatal, high risk OB, cardiology, perinatal and pediatrics.

-- Regionalization of dental services has increased the number of dental clinics in the ambulatory care centers. This has provided experience for all practitioners through rotation of work assignments.

-- With the opening of the Southeast Comprehensive Health Center, there are now three health facilities with uniform medical records. Others are the Compton Neighborhood Health Center and MLK. In the future all health facilities will convert to a single record system.

-- A new residency program in family practice has been established at MLK, emphasizing disease prevention, early detection and continuity of care.

-- MLK has become the community's primary source of health

manpower. Sixty-eight per cent of the medical and allied health graduates from King training programs are now giving care in the region.

-- Since the first King-Drew class graduated in 1974, a total of 154 resident physicians and 395 allied health personnel have completed training.

-- A regional neonatal program was developed in response to the high infant mortality rate. It accepts patients from surrounding community hospitals and health clinics which do not have the facilities to care for very sick infants.

-- The Department of Internal Medicine has rotated residents through health centers. This has been on a full-time basis at the Compton center, where faculty physicians are conducting a cardiology clinic.

-- MLK is now assisting the health centers in the reading of electrocardiograms.

-- An interfacility referral system is providing patients with direct access from the Health Center to the medical subspecialty clinic or ancillary service, e.g., lab, X-ray, EKG, nuclear medicine.

-- One example of the important work being done by the Public Health Investigator lies in VD control. After receiving reports from medical facilities, he contacts and interviews the patient, locates sexual contacts, and brings about treatment. He assists the PHN in hard-to-locate cases and is responsible for initiating legal action. PHI is an invaluable aspect of the total DHS program.

-- The assessment conducted for the 1976-77 county Short-Doyle Plan showed that less than half (44%) of the total projected need for service is being met; 54 per cent of adult service and 30 per cent for child-adolescent service. The lack of services for minors is particularly serious considering that 41 per cent of the population in the region is under 20 years of age and service to this group is viewed as a high county priority.

-- Considerable time has been devoted to improving coordination between services offered by the MLK Department of Psychiatry and the Regional Mental Health Services. MLK psychiatric residents will rotate through the Regional Office Psychiatric Emergency Service as an initial broadening of their training.

-- The roles of the MLK medical and support service chiefs have been expanded to include regional responsibilities. Medical departments participated in the program design of the Southeast Comprehensive Health Center and this experience has led to a branching out of these services into the ambulatory care centers.

-- MLK was awarded its second consecutive two-year accreditation award following the JCAH/CMA Consolidated Hospital Survey.

San Gabriel Health Services Region

-- San Gabriel Valley was one of the two pilot regions activated in March 1973 and has been exemplary in its effort to create a unified system responding to the needs of the San Gabriel Region residents.

-- The merger of community health services has occurred in three health centers: La Puente, Whittier and Pico Rivera. Mental Health patient visits have climbed by 30 per cent during the past two years.

-- A triage screening mechanism has been implemented in all health centers to assist walk-in patients.

-- Certain levels of ambulatory care have begun in health centers. Pico Rivera is the most complete in terms of ambulatory care delivery. The center is one of the most recently constructed in the region and its clinical design permits full development of medical services.

-- The past two years have seen a 15.5 per cent increase in ambulatory care visits. This figure means that about 40,500 patients who would otherwise have had to travel considerable distances to County-USC Medical Center were able to receive care for minor and episodic illness at their local health center.

-- As a means of establishing linkage between outpatient and inpatient services, thirty beds on the medical wards at County-USC Medical Center were designed for SGV patients.

--With assistance from the USC School of Medicine, the Region has recruited four highly qualified young internists who developed urgently needed adult outpatient service components in the health centers.

-- A major expansion of family planning services was implemented, making services available within most of the community health centers. Six thousand patient visits are projected during the first year of the program.

-- Federal funding in the amount of $250,000 annually made possible the opening of the Alcohol Rehabilitation Clinic, serving 700 patients monthly.

-- Low cost vision care to primarily children of indigent families is being given at the Baldwin Park Health Center. Over 1,000 patients were served during the first year. This is an HEW-funded

program to develop student interest in working in underserved areas.

-- An important consideration during this time of rapid expansion into ambulatory care has been the need to maintain adequate levels of public health services.

-- The Region has carefully and regularly monitored certain public health and communicable disease indicators to insure that preventive care programs are maintained, e.g., VD and TB control.

-- The successful implementation of the Child Health and Disability program will have a strong impact on prevention of childhood diseases and disabilities.

-- The Region has worked consistently to increase immunization levels. A 19 per cent increase in the number of immunizations has occurred.

-- A significant step was the administrative joining of Rancho Los Amigos Hospital to the region.

-- Major renovations and alterations were undertaken throughout the various health centers.

-- The county's first regional advisory council was organized. This 30-member organization serves as an essential mechanism for citizen input and participation.

-- National recognition has been given to the biomedical engineering program at Rancho. The neuromuscular assist device was cited as one of the top ten engineering achievements in 1974. The device has been successful in correcting foot drop in stroke patients.

-- Approximately 160 persons are enrolled in the Rancho cardiology rehabilitation and exercise program, a means of enabling victims of severe heart attacks and heart disease to cease being cardiac cripples and return to normal activities.

-- Because many private hospitals are now developing skills necessary to treat paraplegics, the overwhelming number of patients now referred to Rancho's 60-bed intensive spinal cord injury service are quadraplegics, the most difficult type of spinal cord injury.

-- A further example of the technological accomplishment at Rancho is the development of the mud bed now being used nationally as an important method of dealing with pressure sores.

San Fernando-Antelope Valley Region

-- One of the most challenging goals accomplished was the unification of functionally alike but duplicated medical programs in

the health centers. Preventive Health Services and Olive View Hospital offered similar medical progrms (PHS-public health, general medical health officer and Olive View outpatient general medical) to eligible patients in the health centers following the 1971 earthquake which destroyed the Medical Center. As a result of the cooperative efforts between hospital staff and health center staff, the medical programs were unified. This was the major step towards the implementation of the department's Ambulatory Care Program and upgrading of preventive health services in health centers.

-- A formal referral linkage between Olive View Hospital and health centers was established to facilitate patient flow within the regional comprehensive health care network. Patients needing specialty medical care unavailable in health centers now are referred through formal channels to the appropriate hospital based service.

-- The Preventive Health Services family medical record and hospital individual record are being combined into an individual record system which retains the best features of both systems. Full conversion will probably take another three to four years. This system eliminates and discourages duplication of records and services to patients seen in health centers and hospital.

-- All patients and/or third party payors such as Medicare/Medi-Cal, Blue Cross, etc., are billed for general medical care received in the health centers, with the exception of preventive and public health services such as VD, TB, immunizations etc.

-- Adult and pediatric general medicine services were established on a forty hour/week basis in four major health centers - North Hollywood, San Fernando, Canoga Park, and Glendale. These health centers experience a total of 90,000 visits a year combined. This program change makes services available on a walk-in basis, Monday through Friday.

-- San Fernando-Antelope Valley Region has widely implemented on an ongoing basis the practice of utilizing nurse practitioners in ambulatory care programs. Nurse practitioners have assisted in the improvement of patient flow in the health centers by examining patients, under protocol, with minor medical problems and allowing the physician to examine, diagnose, and treat patients with more severe medical problems. Nurse practitioners are a valuable asset to San Fernando-Antelope Valley Region's ambulatory care program.

-- The National Institute for Alcohol Abuse and Alcoholism awarded a grant for Services for Problem Drinking Drivers beginning January 27, 1976 for San Fernando-Antelope Valley Region. The program has been implemented. It provides diagnostic, evaluation, referral services and treatment of alcoholic patients in San Fernando Valley.

-- The San Fernando-Antelope Valley Region's Mental Health programs: Olive View Mental Health outpatient and inpatient, and the three mental health regional services; North County, East Valley, and West Valley, have been unified and are now directed by the Regional Chief of Mental Health Programs.

-- Mental Health billing, formerly done by Mental Health Administration downtown and in San Fernando-Antelope Valley Region, was regionalized. All billing for mental health services is done by regional billing personnel. This action improves efficiency and responsiveness of billing functions.

-- Several actions are initiated in upgrading the public health/preventive health program in the region's health centers. First and most important was the increased organizational emphasis in the public health/preventive health program. Health Officers who were formerly responsible for clinical and administrative activities as well as public health in their respective health districts were reassigned to devote full-time to upgrade public and preventive health services in the health districts.

-- Thirdly, nurse directed clinics were established for patients needing follow-up on public health problems such as venereal disease, tuberculosis, etc., which do not require physician's attention, and for immunizations.

Olive View Medical Center

-- On November 22, 1974, the Regional Director assigned to the Medical Director of Olive View Medical Center all Personal Health Services Programs operated in all health centers and subcenters in the region, with the exception of centers and subcenters in the Antelope Valley. Over the next few months, services formerly provided by the Department of Health were merged with these formerly provided by the Department of Hospitals. Administrative lines of authority and responsibility were unified for all personnel providing medical, dental, nursing, X-ray, laboratory and pharmacy services.

-- During the 1974-76 biennium, the affiliation of Olive View Medical Center with UCLA experienced its greatest period of expansion. The Department of Internal Medicine assumed the responsibility for virtually all inpatient and outpatient services at Midvalley. A close relationship was established between the Sepulveda Veterans Administration Hospital and Olive View. It is anticipated that this relationship will be extended into many of the surgical specialities. Since July 1975, the Department of Surgery at UCLA has assumed the responsibility for General Surgical Services at Midvalley. The Department of Internal Medicine, Radiology, Surgery, and Pediatrics are chaired by physicians who hold joint Olive View-UCLA appointments. The volume of service provided by UCLA faculty is steadily increasing.

-- Admissions to Olive View Medical Center increased by 20 per cent. The number of operations increased by 34 per cent. A much more seriously ill and complicated patient population has been experienced since the development of the UCLA affiliation in Internal Medicine and Surgery. This has been reflected in substantial increases in the workload of the Radiology Department and the Pathological Laboratories.

-- A grant for Family Planning Services in the San Fernando/ Antelope Valley Region was negotiated with Los Angeles Regional Family Planning Council and became effective in January 1975. The grant was the first in the County system which was based on an integrated program in the hospital and community health centers, and provided all levels of service from nurse-practitioner clinics through complication visits and the provision of surgical sterilization procedures.

-- Near the end of Fiscal Year 1974, the Board of Supervisors approved the reduction in scope of the Olive View Replacement Facility. This reduction from 576 to 350 beds was consistent with the DHS Master Plan for health services. The 1974-76 biennium saw redrawing of room programs and schematic drawings, and completion and approval by the State Office of Architecture and Construction and the State Department of Health.

-- March 1975, saw the first joint JCAH-CMA Survey Team at Olive View-Midvalley, and the first accreditation survey since the 1971 earthquake. The surveyors were complimentary of the Olive View programs, and particularly of the patient care audit work being done. The JCAH issued a full two-year accreditation.

-- On March 1, 1976, a new Outpatient Billing Rate System was implemented. This system, replacing the "All-Inclusive Rate," charges on a basis more closely related to the actual service rendered to the individual patient. The immediate impact was favorable, in that patients receiving bills through the McAuto System found their charges to be generally more reasonable.

Mira Loma Hospital

-- The staff at Mira Loma Hospital feel strongly that the health services provided through the current inpatient and outpatient programs, with some modifications such as surgery and intensive care capabilities, can be provided to the Antelope Valley community within the current identified fiscal restraints. Although there have been peaks and valleys in the involvement of Mira Loma Hospital with proposed program cuts, Mira Loma Hospital looks forward for a resolution of fiscal capabilities and allocation as well as stabilization of approved programs.

-- JCAH-CMA Joint Survey resulted in a two-year accreditation

for Mira Loma Hospital.

-- Nursing and clerical staff formerly known as Preventive Health personnel have been integrated into the ambulatory care structure of Mira Loma Hospital. Staff are assigned interchangeably to hospital or outlying clinics. Retraining of public health nursing personnel will be necessary in order to complete the consolidation of ambulatory care functions. Integration of Mental Health activities has been attempted for a lesser period of time.

-- The acute medical inpatient program encumbers approximately one half of the functional bed capacity of the hospital. Patients are treated for a variety of medical as well as chest problems including TB. Approximately 90 per cent of admissions are local residents.

-- The long term skilled nursing inpatient program encumbers approximately one half of the functional bed capacity of the hospital. Treated are patients, who, while they do not qualify for acute care in terms of third party payor reimbursement standards, are largely in medical conditions which make them unacceptable occupants of private nursing homes. Approximately one half of admissions are local residents.

-- The outpatient program provides general as well as specialized ambulatory care. It is the chief source of inpatient admissions and threats only local residents.

Antelope Valley Rehabilitation Centers

-- The Antelope Valley Rehabilitation Centers are composed of two separately located Centers (Acton and Warm Springs) which provide comprehensive ambulatory and rehabilitative services for male and female indigent patients suffering from alcoholism as well as multiple physical, mental, and social disabilities including general social breakdown.

-- The major services provided at the Centers seven days a week include 24-hour medical/nursing care, mental health services, and therapeutic recreational/occupational services. In addition, the two Centers have a vocational adjustment program in which each patient is given an actual job assignment to perform within his physical and mental capabilities.

-- In April of 1975, the Board of Supervisors instructed the Director of Health Services to implement a women's residential alcoholism rehabilitation program as proposed by the Acton Rehabilitation Center. This program opened in July 1975 providing comprehensive alcoholism services to indigent women. The 20-bed unit provides some relief in meeting the large community demand at no additional county cost.

-- The Center's dispensaries were licensed as outpatient clinics in 1974 under the auspices of Olive View Medical Center. This action qualified the centers to become providers under the Medi-Cal program which generates revenue for the county as medical services are rendered.

--The Antelope Valley Rehabilitation Centers have actively investigated the effectiveness of their alcoholism program for the past two years. It is commonly accepted that program evaluation is a necessary prerequisite to the improvement of any program. Preliminary data indicate that the centers have been relatively successful in treating the chronic, indigent alcoholic.

-- In September 1974, a forest fire forced the evacuation of the residents of the Warm Springs Rehabilitation Center to the Acton Rehabilitation Center, a distance of 47 miles. The evacuation was successful and dramatized the necessity for disaster preparation and drills.

Coastal Region

-- During this period, the Coastal Region continued the refinement of the Health Services Region concept initiated in the previous two-year period. Hospital based programs at Harbor General and Long Beach General Hospitals were called upon to provide supporting services to community based Preventive Health and Mental Health clinic programs. The contracts portion of the regional program to augment county-run programs took on an increased importance under the regionalization concept.

Harbor General Hospital

-- The Joint Commission on Accreditation of Hospitals and the California Medical Association granted a two-year accreditation to Harbor General Hospital during this period. The accreditation status is contingent upon submission of progress reports to JCAH detailing corrective measures being taken with regards to environmental deficiencies and delinquent medical records.

-- A new surgical acute care ICU was completed during this period. This service provides eighteen beds in the main unit plus one bed for monitoring. This new unit provides sophisticated monitoring and management of acutely ill surgical and trauma patients.

-- The Pain and Nerve Block Clinic opened in new quarters

in D-4 barracks. All twelve post anesthesia recovery room beds are now monitored including a central unit at the nursing desk.

-- New reporting and record keeping systems for Master Project and Cal-OSHA were implemented. The implementation of the Master Project greatly impacted the workload of admitting, identification, and insurance staff in Medical Records.

-- Computerized print-out for clinic appointments was initiated which reduced typing workload for making appointments.

-- During this period, six capital projects were approved. Four of these have been completed and two are scheduled for completion in the Fall of 1976. Additional parking for two hundred cars was also provided during this period.

-- An estimated 100,000 square foot increase had taken place in the form of trailers and building additions over the past few years. This has resulted in a sharp increase in utilities and maintenance needs by these new functions.

-- Several nursing education accomplishments were achieved. A planning patient care workshop was conducted for registered nurses on three shifts to help meet accreditation standards. A manual for clerks was written and distributed. Approval was received for a provider for registered nurse continuing education units. A cardiac rehabilitation class for patients, families, and friends has received praise from the community. They are taught cardiac pulmonary resuscitation. The nursing instructors also participate in career day sponsored by the Southern California Occupational Regional Center.

-- Pharmacy initiated a region-wide program of supplying medications to the Preventive Health and Mental Health clinics within the Coastal Region. Pharmacy services also provided assistance to free clinics operating in the region in the form of studies on drug distribution, security and storage.

-- Pharmacy noted a marked increase in the production of intravenous preparations not commercially available at Harbor General Hospital especially in the fields of cardiology and pediatrics. Improved methods of dispensing and controlling narcotics and control drugs were completed.

-- Dietary initiated special nutritional classes for diabetics, cardiac care, and pediatric patients. Harbor General Hospital's Food Service Director participated with other directors in the Department of Health Services in rewriting specifications to obtain a better quality level of food.

-- The Master Project was implemented at Harbor General Hospital. From an operational viewpoint, Harbor's controls and

methods have been successful.

-- An outpatient clinic chart request system was initiated which has decreased the personnel requirements in the appointment center and improved the reliability and effectiveness of the entire outpatient appointment system. A centralized bed control system was also implemented. This system controls all inpatient movements and provides timely and accurate billing data.

-- A physician numbering system which provides a controlled assignment of unique numbers to each medical staff at Harbor General Hospital was also initiated. This system is being utilized for ancillary orders and chart documentation. An incomplete chart system was also implemented to assist medical workers and the Medical Department at Harbor General in the control of chart completion by physicians, residents and interns.

Long Beach General Hospital

-- Long Beach General Hospital was surveyed by the Joint Commission on Accreditation of Hospitals in the Fall of 1974, and received full accreditation for two years. An ambulatory care manual was developed during this period in preparation for the survey by the Joint Commission on Accreditation of Hospitals.

-- The Commission on Accreditation of Rehabilitation Facilities also granted Long Beach General Hospital full accreditation for a period of three years.

-- Long Beach General Hospital's alcoholism program has received widespread publicity during this period. Several articles and television programs have specifically featured Long Beach General's alcoholism service making note of the contribution being made to the community at large. The alcohol service has noticed a trend towards younger seriously handicapped individuals combining alcohol and soft drugs.

-- During this period, the budget for Long Beach General Hospital's programs was reduced by 100 inpatient beds and curtailment recommended for a number of supporting services at El Cerrito Health Services Center.

-- As part of regionalization, Long Beach General Hospital is providing full laboratory and X-ray services to the Bellflower and El Cerrito Ambulatory Care Programs. Referrals to specialty clinics are also received from these programs. Outpatient visits as a result have increased from an average monthly total of 400 to 1700 during this period.

-- The dental clinic was remodeled at Long Beach General Hospital and has enabled the clinic to handle an increased volume of

patients. During this period, the infectious waste room and cardio-pulmonary laboratories were also completed.

-- The first phase of the Master Project was successfully implemented. The labor cost distribution system was also implemented to comply with California Hospital Facility requirements. Various informational reports relating to employees' salaries and labor will be generated from this system. The billing unit was reorganized during this period and moved to El Cerrito Health Services Center. Billing production has sharply increased as a result of combining the two programs in one location.

-- During this period, the outpatient clinic has gone from virtually no visits to between 75 and 100 unscheduled walk-in visits per day. Another 25 to 50 consultation visits are also seen daily from health centers throughout the Coastal Region. A total of approximately 25,000 visits are, therefore, made annually to Long Beach General's Outpatient Department. Future growth is anticipated as the Outpatient Department continues to be identified as a key health resource by the communities surrounding Long Beach General Hospital.

-- The Long Beach Community Advisory Council was formed during the period of this biennial report. In the last eighteen months, a close working relationship has evolved between the council and the administrators of Long Beach General Hospital.

Preventive Health Services

-- The interaction between health centers and the hospitals in the Coastal Region has been enhanced in many ways. The hospital based department chairmen have been very supportive and a good relationship exists with the health centers. This provides needed links for two-way referrals, inservice staff education and specialty consultation. The principal viable remaining portion of ambulatory care is in pediatrics. Most health facilities are still able to produce some sick child care in their integrated clinics.

-- Venereal disease and tuberculosis incidence continues to increase. The region was studied by experts in the last six months of this period, documenting the needs of the region to have special teams to counteract the spreading trend in tuberculosis. The needs were documented, presented to the Board of Supervisors and a special tuberculosis staffing program was approved.

-- Effective midsummer 1975, the State of California passed into law a measure whereby each child in the state was required to have a complete physical prior to passing from kindergarten to first grade. Funds were set up to finance this activity if the recipient met certain financial perimeters. An initial staffing of four positions for Coastal Region based at Harbor General Hospital has been

provided with the initial funding under the Child Health and Disability Program (CHDP). After thousands of examinations statewide, Sacramento realized that there were not sufficient providers to affect this activity in the time remaining. A change in the law postponed its effective date until fall of 1976. The Coastal Region is attempting to expand this screening program at all of the health centers in the region in the hope of bringing in additional revenue to permit a limited expansion of medical services to this age group.

-- The region gave 139,446 immunizations in the calendar year 1975. Area print-outs available mid-January 1976 pointed out deficiencies in areas and appropriate efforts were made to rectify this during the last six months of the biennial period.

Mental Health Services

-- Funds budgeted for Mental Health Services, when taking into account inflationary factors, have not kept up with the demand for these services, resulting in less resources having to treat an increased number of mental health problems presenting themselves throughout the Coastal Region.

-- Request for emergency services have increased approximately 20 per cent in the Mental Health Regions and 10 per cent at Harbor General Hospital. This increase in caseload has resulted in the patients having to be seen less often in the Mental Health Regions. Harbor General Hospital has been able to absorb the increase without a decrease in visits per patient.

-- Actual time spent with patients has necessarily had to be reduced. In most of the mental health centers, the average number of visits per patient has decreased from 3.5 to 2.5.

-- At Harbor General Hospital, requests for liaison consultation have increased 25 per cent in this period.

-- In the Mental Health Regions, the increase in the conservatorship caseload has decreased the ability of the staff to respond to acutely ill patients. An equivalent of one staff member per region has had to spend at least one day per week completing these evaluations and taking staff away from Psychiatric Emergency Team (PET) responsibilities.

Central Region

Ambulatory Care Services

-- The Montebello Satellite Clinic was opened in October 1975 to provide prenatal care to the community.

-- Casa Maravilla Clinic was opened in the housing project with an innovative approach to health care delivery. Using nurse practitioners, the clinic is a pilot for the department to explore and study this form of providing ambulatory care.

-- The Brooklyn Clinic was opened to further service the expanded health needs in the East Los Angeles community.

-- Opened a newly remodeled Southwest Health Center in March 1976 to upgrade health service delivery capabilities within Central Region.

-- The following new programs were initiated in Central Region:

1. Rheumatology Clinic for Senior Citizens.

2. Flu Vaccine Clinics for Senior Citizens.

3. TB Follow-up Clinics/Mantoux Skin Test Clinics; the latter being conducted in various community and industrial sites; and

4. Child Health Disability Program

-- Pharmacy contract between the County and USC School of Pharmacy which established a pharmacy service program for primary care services in East Los Angeles. This program serves as a model in the development of pharmacy related programs in Central Region.

-- Expanded the Region's Alcohol Program to include evening clinics.

-- Expanded the Family Planning and Immunization Programs within the Region.

Mental Health Services

-- Effective December 16, 1974 all Mental Health Services staff in the Central Health Services Region were integrated to form a single organization for Mental Health Services. This has enhanced Mental Health Services in the Central Region by improving communication and consolidating program efforts between Psychiatric Hospital and the Regional Mental Health Offices.

-- There have been no significant changes in the service

program in the past two years as a result of budgetary uncertainty between the State and County. From year to year we have been uncertain as to whether the state would continue to fund existing programs. As a result, the region has concentrated its efforts on the best utilization of existing resources.

-- Due to freezes on hiring, there were severe problems in maintaining existing programs with minimal resources. Lack of adequate clinical staff has resulted in a reduction in Psychiatric Emergency Team (PET) responses. Coupled with the freezes, the closure of privately operated community resources (The Whitney Young Memorial Center and the Crenshaw Community Service Center) and the collapse of the Resthaven Community Mental Health Center has added to the burden on already strained services.

-- In April 1976, the South Central Satellite and a portion of that facility's staff were transferred from the Central Health Services Region to the Southeast Health Services Region.

-- In February 1976, Psychiatric Hospital was inspected for the first time as a free standing Psychiatric facility by the Joint Commission on Accreditation. A favorable inspection resulted in the granting of a two-year accreditation.

Crippled Children Services

-- Los Angeles County's Crippled Children Services, located at 2064 Marengo Street, Los Angeles, California, has been in continuous operation since it was established in 1948 by County ordinance. The purpose of the program is to help physically handicapped children develop to their fullest capacity for independence. Its primary function is to obtain specialized medical services for handicapped children whose families are unable to do so, in part or whole, due to the overwhelming or continuing expenses resulting from major disability.

-- The program has experienced significant growth during this biennium, due partly to the fact that children who previously would not have survived are now surviving, and they have many multiple conditions which necessitates the authorization of more specialists and hospitalization. The caseload reflects a growth trend of approximately 8 per cent per year with a current total of 22,364 active cases.

John Wesley Hospital

-- The transfer of the oncology program to the LAC/USC Medical Center and the liver service to Rancho Los Amigos Hospital occurred in December 1976.

-- A program for providing psychiatric services in the John Wesley Neighborhood Health Center has been established through the cooperative efforts of the LAC/USC Medical Center Department of Psychiatry and the Central Region Mental Health Services.

-- Arrangements have been made with the South Central Mental Health Service Psychiatric Emergency Team to provide psychiatric consultations for John Wesley patients.

-- The John Wesley NHC initiated a hypertension screening program in cooperation with the Southwest Health District Community Health Center.

-- There has been an ongoing program to employ multilingual employees to permit provision of suitable services to non-English speaking patients, primarily those who are Spanish speaking. In addition, classes in Spanish have been offered to employees who are non-Spanish speaking.

-- A patient teaching program in both English and Spanish for prenatal patients has been developed and is being carried out by the Nursing Division.

Los Angeles County-USC Medical Center

-- The contribution made by the Los Angeles County-USC Medical Center in providing care for approximately 100,000 inpatients and a million outpatients annually ranks as one of the nation's outstanding medical achievements and is a tribute to the staff which is called upon consistently to respond to major medical demands. During the past two years the Medical Center has felt the impact of the fiscal problems and shares with the other hospitals the difficulty in recruiting critical care nurses.

-- In many ways the Medical Center reflects the state of the health of the community and is an excellent indicator of where problems exist in obtaining medical care in the community. During the malpractice crisis, the Medical Center often was the only community resource in such areas as neurosurgery, orthpedics and obstetrics. Very soon into the action by private physicians, the Women's Hospital found itself running far beyond capacity, a situation which has never returned to normal simply because many private doctors will no longer provide obstetrical care to high risk Medi-Cal patients. Despite the many difficult problems caused by reduced staffing levels and budget curtailments, the Medical Center continues to meet the challenge of caring for massive numbers of patients with quality medical and nursing programs. It is not the purpose of this report to catalogue all of the programs in the LAC/USC Medical Center or in the Department of Health Services but mention must be made of consistent superior performance by the Departments of Surgery, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.

-- One of the major programs in the General Hospital is the Department of Internal Medicine, which has responsibility for 620 beds and which annually admits 30,000 patients. It also includes numerous specialized services, including three cardiac catheterization laboratories, pulmonary function lab, chronic dialysis and renal transplantation unit, a 16-bed coronary care unit, a 12-bed general medicine intensive care unit, five-bed respiratory intensive care unit, and a communicable disease unit housed in the Pediatric Pavilion.

-- The coronary care unit was expanded last year from 12 to 16 beds as a result of the hiring of additional nursing staff. Extensive laboratory and computer facilities continue to monitor special treatment and studies.

-- Since December 1975, the pulmonary physiology laboratories have been providing blood gas analysis on a 24-hour basis and ventilatory capacity tests on patients throughout the Medical Center. In the past two years the samples analyzed has doubled due to the increased awareness of physicians of the necessity of pulmonary physiology testing.

-- The Department of Emergency Medicine has made significant progress in training physicians as emergency specialists and allied health personnel, and in rendering acute care for all types of major emergencies. A Medical Alert Center was established which coordinates the medical response to outside emergency situations. The department is now the base station for nine paramedic units and serves as the back-up base for eight additional units.

-- The Diagnostic and Evaluation Unit was opened in 1974 and provides an 18-bed ward for orthopedic cases and an 18 and 12-bed ward for evaluation and stabilization of patients being considered for admission to Internal Medicine.

-- The Los Angeles County-USC Cancer Center was named a regional comprehensive cancer center. This designation by the National Cancer Institute carried strong financial support. A construction grant of $2.1 million funded a new Research Laboratory Building and the remodeling of three wards in the General Hospital.

-- On Ward 10-600 a 20-bed oncology investigation unit has been opened which provided care to 258 adult patients with cancer, one third of whom were being treated on investigative treatment protocols.

--An important development has been the formation of organ site teams, which permit multi-disciplinary specialty cooperation during the patient's diagnostic and treatment phases.

-- Both the Women's Hospital and the Pediatric Pavilion have increased the scope and quality of service. Progress has been

achieved through many new diagnostic and treatment methods being pioneered by Medical Center physicians. These involve such areas as fetal monitoring, newborn intensive care, and several prenatal diagnostic techniques which are available only in major teaching centers. It was in recognition of this type of advanced care that Harbor General, Martin Luther King, Jr. General Hospital and the LAC/USC Medical Center's Women's Hospital were selected as regional perinatal centers and received national recognition.

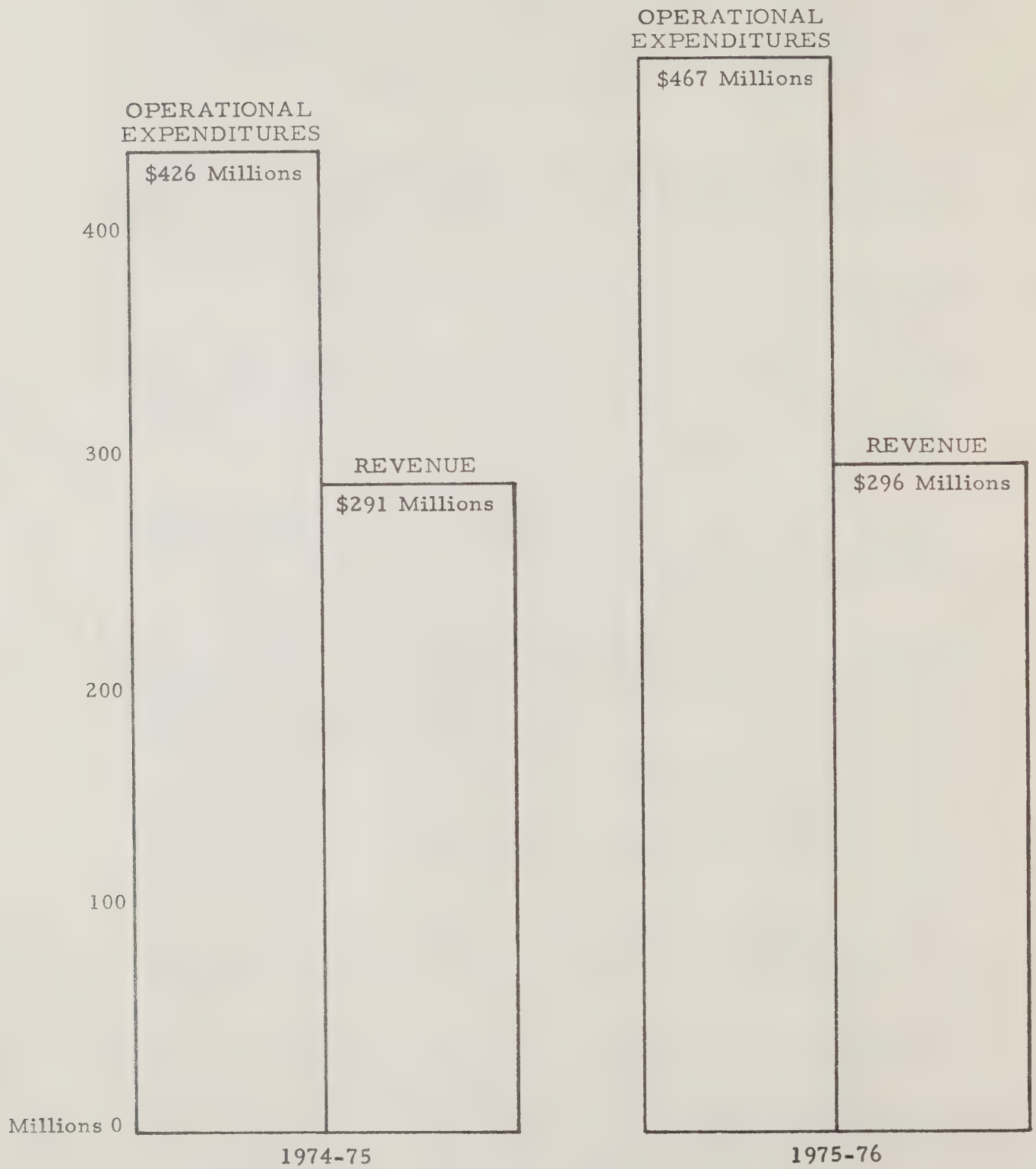
-- The Pediatric Pavilion and the Department of Pediatrics consist of four distinct but interrelated units: the inpatient medical and surgical services, the communicable disease service, outpatient department and the newborn service housed in the Women's Hospital. The newborn program increased the volume of service by at least fifteen per cent. The Genetics Division continues as a prime resource for many hospitals. Requests for services have increased as a result of the expanding use of amniocentesis.

-- The medical work in the Pediatric Pavilion extends to all areas of the Medical Center. It contains one of the community's most important resources for the protection of public health in the communicable disease unit, which cares for both children and adults suffering from infectious diseases.

-- Pediatric emergency services climbed by 22 per cent during 1975-76, rising from 72,448 children to 88,332. Triage functions were developed as well as various screening programs, with an increased emphasis on tuberculosis.

-- The Neonatology Division of the Department of Pediatrics provides supervision for the newborn nursery in the Women's Hospital. Neonatal mortality has continued to decrease from 9.6 per thousand in 1974 to 8.1 per thousand in 1975. This is below the California average despite the fact that the Medical Center's patient population is predominately high risk. It is also lower than any hospital in the country of comparable size.

COMPARIONS OF REVENUE AND EXPENDITURES
FOR DEPARTMENT OF HEALTH SERVICES
1974-76



COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

Comparative Hospital Patient Data

Fiscal Year 1974-75

	LAC-USC	Harbor	M.L.K.	John Wesley	Long Beach	Olive View	Mira Loma	Los Amigos	AVRC Acton	AVRC Warm Springs
Inpatient Days										
Admissions	78,664	21,848	12,349	5,719	5,780	4,480	1,422	7,600	867	638
Patient Days	571,001	177,373	101,106	38,719	99,880	41,986	35,039	252,761	116,695	79,107
Census (Budget	1,630	514	275	106	300	141	100	800	326	216
Census (Average	1,569	487	277	106	273	115	97	697	319	213
Average Length of Stay	6.4	7.0	6.0	7.0	18	9.4	18	29	131	101
Occupancy Percentage of Real Capacity	70%	65%	82%	76%	84%	75%	77%	75%	102%	95%
Occupancy Percentage of Budget	96%	95%	100%	100%	91%	82%	97%	87%	98%	99%
Outpatient Visits										
Clinic Visits	577,028	200,681	210,101	25,431	25,860	215,991	17,647	146,871	4,055	2,248
Admitting Room Visits	262,314	73,846	46,627	Ø	Ø	19,613	Ø	Ø	Ø	Ø
TOTAL OUTPATIENT	839,342	274,527	256,728	25,431	25,860	235,604	17,647	146,871	4,055	2,248

Fiscal Year 1975-76

	LAC-USC	Harbor	M.L.K.	John Wesley	Long Beach	Olive View	Mira Loma	Los Amigos	AVRC Acton	AVRC Warm Springs
Inpatient Days										
Admissions	83,122	18,989	17,652	6,070	7,578	4,946	1,330	7,223	1,209	707
Patient Days	570,042	165,234	107,307	39,895	95,141	42,419	29,614	229,761	106,002	76,782
Census (Budget	1,577	500	300	106	300	141	100	737	326	216
Census (Average	1,557	452	294	109	260	116	81	628	290	211
Average Length of Stay	5.8	7.4	6.1	7.0	12.7	8.4	17.6	26	86	98
Occupancy Percentage of Real Capacity	69.5%	68.8%	74.6%	78.4%	80.2%	78.5%	75.3%	77%	88.7%	94.2%
Occupancy Percentage of Budget	99%	90%	98%	103%	87%	82%	81%	85%	89%	98%
Outpatient Visits										
Clinic Visits	471,579	183,171	162,232	49,082	38,233	266,160	26,732	129,126	4,119	2,240
Admitting Room Visits	186,304	91,373	95,270	Ø	Ø	57,960	Ø	Ø	Ø	Ø
TOTAL OUTPATIENT	657,883	274,544	257,502	49,082	38,233	324,120	26,732	129,126	4,119	2,240

PREVENTIVE HEALTH SERVICES

CLINIC SESSIONS AND ATTENDANCE STATISTICS BY REGION

Fiscal Year 1974-75 and 1975-76

CLINIC SESSIONS AND ATTENDANCE

REGIONS	Year	All Clinic Sessions		Total Attendance		Physician Sessions Only		Attendance at Physician Sessions	
		No.	%	No.	%	No.	%	No.	%
Total, County	1975-76	98,270	100.0	1,796,427	100.0	54,711	100.0	631,193	100.0
	1974-75	85,624	100.0	1,610,364	100.0	51,737	100.0	604,875	100.0
Percent Change ...		+14.8		+11.6		+5.7		+4.4	
Central HSR	1975-76	25,243	25.7	535,522	29.8	13,705	25.0	179,576	28.5
	1974-75	25,044	29.2	492,573	30.6	14,047	27.2	166,617	27.5
Percent Change ...		+0.8		+8.7		-2.4		+7.8	
Coastal HSR	1975-76	18,013	18.3	374,433	20.8	11,204	20.5	141,020	22.3
	1974-75	16,435	19.2	332,522	20.6	10,974	21.2	127,620	21.1
Percent Change ...		+9.6		+12.6		+2.1		+10.5	
SF/AV HSR	1975-76	16,933	17.2	264,633	14.7	9,129	16.7	79,881	12.7
	1974-75	10,489	12.3	218,364	13.6	6,641	12.8	77,099	12.7
Percent Change ...		+61.4		+21.2		+37.5		+3.6	
SGV HSR	1975-76	22,576	23.0	355,993	19.8	10,339	18.9	108,233	17.1
	1974-75	18,539	21.7	311,754	19.4	9,852	19.0	109,255	18.1
Percent Change ...		+21.8		+14.2		+4.9		-0.9	
Southeast HSR	1975-76	15,505	15.8	265,846	14.8	10,334	18.9	122,483	19.4
	1974-75	15,117	17.7	255,151	15.8	10,223	19.8	124,284	20.5
Percent Change ...		+2.6		+4.2		+1.1		-1.4	

MENTAL HEALTH SERVICE STATISTICS

Mode of Service	Units of Service	
	1974-75	1975-76
24-Hour Care	152,861	169,102
Partial Care	271,052	264,930
Outpatient Service	791,531	786,539
Community Service	57,322	65,575

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